



PRACTITIONER UTILIZATION:

Trends Within Privately Insured Patients

Released March 2004

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Chairman



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Executive Summary

The number and complexity of professional medical services consumed by insured Maryland residents grew substantially in 2002. From 2001 to 2002, Maryland private insurers reported a 12 percent increase in the total quantity of physician and other practitioner services used by non-elderly privately insured Maryland residents. Some of that increase is due to changes in data reporting as HMOs shifted away from capitation toward fee-for-service (FFS) payment. Most of it, however, reflects continuing growth in service use by the insured population. The increase was mainly due to a larger quantity of care consumed by each insured person, and only to a lesser extent was driven by a small increase in the number of persons using care.

For the segment of the industry for which the claims data are most reliable — non-HMO plans — total reported practitioner spending grew 18 percent from 2001 to 2002, and a cumulative 51 percent from 1999 to 2002 (Table ES-1). Much of this increase was due to an increased number of persons using care in these non-HMO plans (including both growth in enrollment and increase in the fraction of enrolled persons using care.) On average, practitioner payment rates for non-HMO plans in 2002 were 2 percent above the 1999 level.

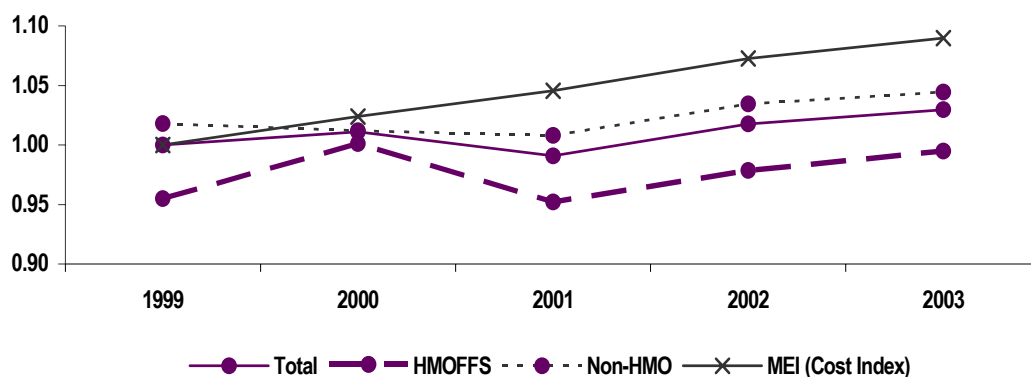
Table ES-1: Estimated Sources of Spending Growth for Non-HMO Plans

Sources of Spending Growth	Growth 1999-2000	Growth 2000-2001	Growth 2001-2002	Cumulative 1999-2002
Increase in Payment Rates	0%	-1%	3%	2%
Increase in Reported Persons Using Services	8	8	8	26
Increase in Services per Reported User	0	5	3	8
Increase in Intensity per Service	2	3	4	9
Total Expenditure Increase	10	16	18	51
Note: Detail may not match totals due to rounding and because growth rates compound (multiply) to create totals.				

In 2002, for the first time since at least 1999, the payment rates for practitioner services began to rise on average, for both non-HMO plans and for the fee-for-service payments of HMO plans (Figure ES-1). Maryland private payers' physician fees had fallen slightly from 1999 through 2001. In 2002, average fees increased 2.2 percent, driven mainly by a large increase in fees for office visits (led by a sharply increased fee level for one major Maryland insurer). Fees continued to rise through the first part of 2003, and by April 2003 average private fees for practitioners' services were about 3 percent above their 1999 level. Although this increase did not keep up with physicians' cost increases over

this period (as measured by the Medicare Economic Index or MEI), it shows that payment rates began to rise somewhat starting in 2002 and continuing into 2003.

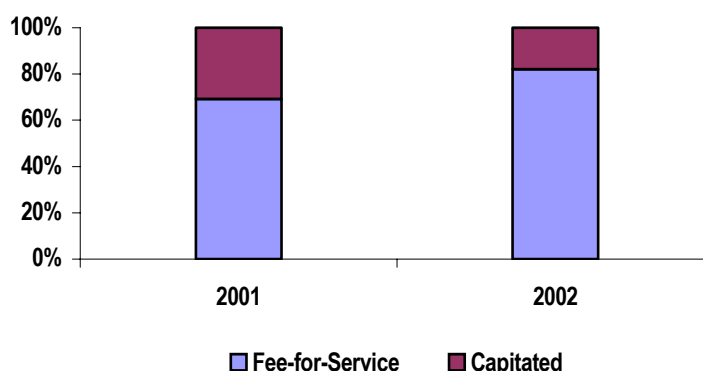
Figure ES-1: Trend in Average Practitioner Payment Levels and Costs, 1999-April 2003



Non-HMO rates are about 3 percent above Medicare rates (on average) and HMO rates are about 3 percent lower in Maryland overall. Different pricing strategies and a different mix of payers, lead to significant regional variations in the gap between Medicare and private sector payment rates. The National Capital Area exhibited the greatest deviation from Medicare rates with non-HMOs paying about 9 percent above Medicare rates (on average), while fee-for-service payments by HMOs were about 5 percent below the Medicare rates (on average). Both types of payers appear to pay relatively well on the Eastern Shore. In the Baltimore region, private HMO and non-HMO rates were modestly below average Medicare rates.

In tandem with the increase in payment rates in 2002, plans sharply reduced their use of capitation as a method of payment in 2002. Although not all HMO capitated care is captured by the Medical Care Data Base (MCDB), the changes in use between 2001 and 2002 are large enough to be clearly indicative of a shift in HMO payment methods. Measured in terms of total relative value units of care, the amount of HMO capitated care fell by more than one-third. Along with the growth in use of fee-for-service payment by HMOs, this pushed capitation from almost one-third of all reported HMO care in 2001 to less than 20 percent of that care in 2002 (Figure ES-2).

Figure ES-2: Capitation and Fee-for-Service Payment as Percent of Reported HMO Relative Value Units, 2001 and 2002



Despite this recent increase in fees, Maryland appears to rank in the bottom one-quarter of all states in terms of the ratio of private payers’ average practitioner fees compared to fees paid by Medicare. Factors contributing to low private fees in Maryland are an abundant supply of physicians, reasonably high managed-care penetration, and location near Northeast states in which private insurers pay relatively low physician fees.

In terms of the other drivers of spending growth in 2002, the fastest-growing broad category of service was imaging. Simple imaging, advanced imaging (MRI, CAT, and Cardiac), and echography all increased more rapidly than the growth for all services. This pattern parallels the results that MHCC reported last year. Procedures, particularly major surgical procedures, were not a significant contributor to spending growth, although these services account for a significant portion of total spending.

The Maryland legislature has recently passed or considered legislation affecting payment to Maryland practitioners. First, Maryland statute sets minimum payment rates for HMO out-of-network care. This is a particularly important consideration for emergency care, where physicians must deliver care regardless of a patient’s insurance status. Using the average payment across all contracting physicians as the “in-network rate” for a particular service, compliance with the statutory minimum payment of 125 percent of the in-network rate did not appear to change appreciably between 2000 and 2002. But payments for out-of-network care fail to meet the statutory minimum by a relatively small percentage, on average, pointing to the possibility that some payers may define the in-network rate using a particular set of contracted rates that are below the overall average. Second, the legislature is considering a ruling that requires plans to pay nonphysician practitioners the same rate paid to physicians for the same services. In 2002, payment rates for nonphysician practitioners averaged about 10 percent below the rates paid to physicians for comparable services.

Finally, the Maryland Comprehensive Standard Health Benefit Plan (CSHBP) is a small-business insurance product whose benefit structure is regulated to ensure a premium no higher than 12 percent of the average Maryland wage.¹ The Maryland Health Care Commission adjusts factors such as deductibles and coinsurance to guarantee that the basic CSHBP product meets this affordability criterion. (Employers may purchase additional coverage to “buy down” the CSHBP deductible or coinsurance amounts.) For practitioners’ services in 2002, the average enrollee out-of-pocket share of costs for CSHBP products was lower than for individually purchased insurance plans, but modestly higher than the out-of-pocket costs required by the average employer-sponsored insurance plan.

¹ In the 2003 session of the Maryland Legislature, Senate Bill 477 lowered the affordability cap to 10 percent of the average Maryland wage.

1. Introduction

This report provides a detailed description of payments to physicians and other health care practitioners for the care of privately insured Maryland residents under age 65. It is based on health care claims and encounter data that most private health insurance plans serving Maryland residents submit annually to the Maryland Health Care Commission (MHCC). Data from 2001 and 2002 are used to track changes in the quantity of care and the price of care, separately, for individuals in health maintenance organization (HMO) plans and individuals in other, non-HMO plans. Some data from earlier and later years are used to supplement the main analysis of quantity and price of care.

This introductory section explains why and how this report is produced. The first part of this section describes the legal mandate for the report and current issues of legislative and policy interest. The second part briefly describes the statistical methods and some significant technical caveats about the underlying data and the conclusions drawn from those data.

Chapter 2 of this report presents an overview of growth in spending and volume of care, in aggregate and separately, for HMO and non-HMO plans. **Chapter 3** compares private payers' fees to Medicare fees, contrasts the fees paid by HMO and non-HMO plans, and looks at trends in private insurers' fees. **Chapter 4** gives a brief summary of major findings. Appendices list the payers contributing data to this report and show the Maryland regions. Technical detail on methodology will be available in a document posted on the MHCC website (www.mhcc.state.md.us).

MANDATE AND POLICY ISSUES FOR THIS REPORT

Each year since 1996, the MHCC has published a Practitioner Report describing the use of insured practitioner services by residents and the associated payments by insurance companies and recipients for those services, as required by Health-General Article § 19-133(g)(2). This report summarizes trends in the volume and pricing of the services of physicians and other practitioners received by privately insured non-elderly residents of Maryland.

One of the main findings of this series of reports is that Maryland private insurers' fees appear to be stable and are relatively low compared to private insurers' fees in other

parts of the United States. On average, the prices that private insurers pay for individual medical services did not increase from 1999 through 2001. Further, average private insurers' rates in Maryland are close to the rates paid by Medicare, while for the United States as a whole, private insurers' rates significantly exceed the Medicare level.²

Against this backdrop of restraint on private fees, the adequacy of physician reimbursement has been hotly debated in the Maryland legislature. Discussion has focused on establishing minimum reimbursement levels for specific groups of physicians who are obligated to provide care to all patients, including physicians working in emergency rooms and trauma centers. These physicians must treat patients regardless of insurance status.³ For insured patients, physicians in these settings must provide care without regard to the payment level or the existence of a contractual arrangement with a patient's third-party payer.

This is a particular concern for HMO patients, because Maryland physicians are barred from charging HMO patients for the balance of a bill beyond the amount the HMO will pay. Such balance billing of HMO patients is not permitted under Maryland law (Health-General Article § 19-710(i)). This prohibition is viewed by policymakers as an important consumer protection feature of Maryland law. The no-balance-billing limitation sharpens the issue of HMO reimbursement because a noncontracting physician is required to provide care in settings such as emergency rooms, but is limited to recovering payment from the HMO plus a small patient co-payment. In the past several years, the General Assembly has taken action to set floors on HMO payments. In 2000, the Maryland General Assembly passed legislation (codified in Health-General Article § 19-710.1) that required HMOs to reimburse noncontracting providers at the greater of 125 percent of the rate the HMO pays for the same service to a contracting provider under written contract, or the rate that the HMO paid in the same geographic area, for the same covered service, to a similarly licensed provider not under written contract with the HMO. In 2002, passage of House Bill 805 (Chapter 250 of the Acts of 2002) signaled the General Assembly's continued interest in setting minimum payment levels for a broader range of services and new interest in examining alternatives to the establishment of piecemeal physician reimbursement floors. The new legislation removed the sunset provisions on the original law and established a floor on payments for noncontracting physicians at the greater of 125 percent of the HMO's fee schedule or 100 percent of what the HMO pays any other similarly licensed provider for the same specific service in a given geographic region. Recognizing the importance of protecting

² Medicare Payment Advisory Commission, *Medicare Payment Policy: Report to the Congress, 2003*, (Washington, DC: MedPAC, March 2003), p. 76.

³ The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to provide the public with access to emergency medical services regardless of the ability to pay.

the State's trauma network, the legislation raised the payment floor for noncontracting trauma physicians to the greater of 140 percent of the Medicare Fee Schedule or 125 percent of the HMO's contracting rate for a given service.

Opinions differ on the impact of the new laws. Many physician groups argue that the provisions in the 2000 and 2002 legislation establishing reimbursement floors have little impact because they apply only to noncontracting providers. They contend that most physicians routinely contract with many HMOs to ensure a supply of patients at their private practices. A contracting physician's reimbursement is not covered by any of these statutes.

Nonphysician groups have also sought legislative solutions to reimbursement issues. In general, these bills seek to peg payments for these practitioners to the levels private insurers pay physicians for the same service.⁴ These efforts have gathered some momentum due to the slow rate of growth in insurer payments and a trend on the part of government payers, particularly Medicare, to pay the same rate to physician and nonphysician providers when the service is in each group's scope of practice. The Maryland General Assembly has not enacted any of these proposals, although new bills appear each year.

The 2002 legislation required the MHCC and the Health Services Cost Review Commission (HSCRC) to study the adequacy of private-sector reimbursement relative to provider costs and to examine the feasibility of expanding the hospital rate-setting system administered by the HSCRC to include hospital-based and university physicians. An assessment on the feasibility of establishing an uncompensated care fund for physician services to parallel that for hospital services was another requirement of the new law.

The two Commissions reported their findings to the Maryland General Assembly in December 2003, and published their findings in January 2004.⁵ In general, they found that private payers' rates significantly exceeded the average practice and malpractice expenses associated with providing care, but that Maryland Medicaid rates were often set below average cost. In general, the Commissions recommended against setting minimum and maximum physician payment rates (other than in those circumstances already defined in law) and noted the difficulty of including university and hospital-based

⁴ HB 411 and SB 437 introduced in the 2004 session of the General Assembly provide that if a service is within the lawful scope of practice of a licensed podiatrist, the insured or any other person covered by or entitled to reimbursement under the health insurance policy or contract is entitled to the same amount of reimbursement for the service regardless of whether the service is performed by a physician or a licensed podiatrist.

⁵ Maryland Health Care Commission and Health Services Cost Review Commission, *Study of Reimbursement of Health Care Providers, Required Under HB 805 (2002)*. (Baltimore, MD: MHCC and HSCRC, January 2004).

physicians in the State's hospital rate-setting system. The study concluded that a more feasible short-term option may be to expand the Maryland Trauma Physician's Fund to include university and hospital-based physicians. Longer-term solutions to all of these problems must focus on expanding access to health care coverage. Some of the key technical analyses from the Commissions' January 2004 report on this topic are repeated in Section 3 of this report.

TECHNICAL BACKGROUND: SUMMARY OF DATA, METHODS, AND CAVEATS FOR THIS REPORT

Tables and figures in this report are based on services and payments captured in the Maryland Medical Care Data Base (MCDB). The MCDB contains extracts of insurance claims and encounter data submitted by most private insurers in Maryland. These are claims for the services of physicians and other medical practitioners such as podiatrists, psychiatrists, nurse practitioners, and therapists. Insurance companies and HMOs meeting certain criteria⁶ are required to submit information to MHCC under the Code of Maryland Regulations (COMAR) 10.25.06 on health care practitioner services provided to Maryland residents. For calendar year 2002, the Commission received usable data from 26 payers, including all major health insurance companies.⁷

Each practitioner service generates a separate record in the MCDB. Patients are identified only by an encrypted number generated by each payer. Insurers use a standard format for reporting the data. In addition to identifying the service provided, each record shows the payments from the insurer and patient (for noncapitated care), patient age and county of residence, physician specialty, and other attributes of care such as site of service and type of coverage.

Interpreting the results of this report requires an understanding of the limitations of the MCDB and of how the MCDB is used to track changes in payments, services, relative value units (RVUs) of care, number of persons receiving services, and the fee level (average payment per RVU of care). This report focuses on the following quantities:

- **Total payments** for practitioner care include payments from the insurer and patient, including any deductible, coinsurance, and balance billing amounts paid directly out-of-pocket by the patient and reported on the claims data.

⁶ The companies are licensed in the State of Maryland and collect more than \$1 million in health insurance premiums.

⁷ A number of small payers received waivers from contributing data, but these payers together account for less than 1 percent of total health insurance premiums reported in Maryland.

- **Count of services** is a simple count of the number of services provided to patients, without regard to the cost, complexity, or intensity of those services. It is, in effect, a count of the number of claims or number of items that were billed.
- **Total RVUs of care** is a measure of the quantity of care, where more complex (and typically more costly) services have higher RVUs. It is a more sophisticated measure of the quantity of care than a simple count of services. Medicare's physician payment system was used as the source of information on RVUs for services. For this report, RVUs from the 2002 Medicare fee schedule were applied to both 2001 and 2002 data.
- **Count of service users** is based on the encrypted patient identifiers reported by the payers. Because payers may use different numbering systems for their different insurance products, the count is done separately for HMO capitated data, HMO fee-for-service (FFS) data, and non-HMO data. The resulting count of persons may be subject to significant uncertainty because the same individual may be numbered separately under a different product.
- **Average fee level or payment per RVU** is calculated from total payments divided by total RVUs. This is the per-unit price of practitioner care, using RVUs to measure the units of care. This figure will be higher in areas where insurers' fee schedules are higher and will increase when insurers raise their fee schedules.

The comparison between the *level* of Medicare and private fees in this report is based on total payments divided by total RVUs of care. The Medicare RVUs provide a common scale for assessing the value of each procedure. Each service has its associated private payment and RVU, and the analysis of prices is based on private payment per RVU compared to Medicare.

The analysis of *trends* in private fees, by contrast, is based on price indices constructed solely from the private plan data. For that analysis, the value of a procedure is not based on the Medicare RVU standard, but instead is based on the average private payment for that procedure. As is typical with analysis of price index data, the value of the price index is set to 1.00 in the initial year of data (1999), and the price level in subsequent years is expressed relative to a value of 1.00 in the base year. For example, a 2 percent inflation in rates between 1999 and 2000 would result in a price index value of 1.02 in 2000.

Two significant changes in the Maryland health insurance marketplace create important caveats for the results shown here. First, one of the largest Maryland insurers consolidated operations of several HMO and non-HMO subsidiaries in 2001 and 2002. These modifications inadvertently led to underreporting of 2002 non-HMO utilization from this insurer. To show a consistent trend from 2001 to 2002, we

excluded this insurer's non-HMO claims from both years of data. Certain results shown here will differ modestly from results published last year because we have excluded that insurer's non-HMO records.

Second, Maryland HMOs reduced the use of capitation as a method of payment by more than one-third in 2002, substituting fee-for-service payments for services that were formerly capitated. **This change will inflate the reported growth in total HMO service use.** For capitated care, payers only report specialty services, not primary care, and sometimes only report tests and procedures. With fee-for-service payment, by contrast, all services are reported. This explains, in part, the high reported rate of growth in HMO volume of care in the MCDB, while total private HMO practitioner spending as measured by the State Health Care Expenditure Accounts (SHEA) rose less than 2 percent.⁸

In general, these data reporting issues may have a strong impact on estimated trends in volume of care, but only a modest impact on the estimated level of fees (that is, payment per RVU of care).

⁸ Maryland Health Care Commission, *State Health Care Expenditures : Experience from 2002*, (Baltimore, MD: MHCC, January 2004).

2. Trends in Total Spending and Volume of Care

This section of the report shows growth in spending and volume of care in total for all private plans, then in detail separately for non-HMO and HMO plans. The reported volume of practitioner care (measured by total RVUs) rose 12 percent, overall, from 2001 to 2002.

As noted in the methods section above, the reported trends in volume of care for 2002 were affected somewhat by changes in data reporting. For non-HMO plans, the spending increase estimated from the MCDB (18 percent) is very close to the 19 percent increase estimated from aggregate data used in the SHEA.⁹ But the estimated increase in total HMO volume of care shown here (8 percent) substantially exceeds the 1 percent HMO practitioner spending growth estimated from the SHEA.¹⁰ This discrepancy is probably due to changes in HMO data reporting, and to the shift from capitated to fee-for-service care.

Despite the uncertainty regarding total service growth, the data allow for some clear qualitative conclusions about factors driving the increased spending. First, for both HMO and non-HMO plans, fee increases began to play a part in driving spending growth upward. In recent years, by contrast, fees had been flat or modestly falling, on average. Second, spending growth was broadly based. Major surgical procedures grew less rapidly than did other types of care, but medical care in general showed relatively high rates of growth. Similarly, spending for surgeons grew less rapidly than did spending for other specialties.

OVERVIEW OF PAYMENTS, SERVICES, AND USERS REPORTED BY THE PLANS

For consistency with prior years' reports, Table 2-1 shows MCDB totals for payments, services, and users of care by type of plan and region. These are for privately insured under-65 patients only, and have been subject to additional screens to remove claims

⁹ MHCC, *ibid.*

¹⁰ MHCC, *ibid.*

Table 2-1: Practitioner Services Data Reported by Plan Type and Region, 2001-2002

PLAN TYPE AND REGION	2002 DATA					PERCENT CHANGE, 2001-2002				
	Payments (\$000s)	RVUs (000s)	Services (000s)	Users (000s)	Pymts Per User	Payments	RVUs	Services	Users	Pymts per User
Non-HMO Plans (see Note)										
Total	\$1,142,410	29,875	19,181	1,330	\$859	18%	15%	11%	8%	9%
National Capital Area	234,012	5,484	3,460	243	962	18	17	11	5	12
Baltimore Metro Area	675,380	18,368	11,844	796	849	21	17	13	12	8
Eastern Shore	73,892	1,909	1,179	93	796	14	12	7	5	8
Southern Maryland	66,307	1,740	1,146	79	835	10	3	3	0	11
Western Maryland	92,820	2,374	1,552	118	785	8	5	6	-2	10
HMO Plans, Fee-for-Service Data										
Total	\$565,875	15,379	7,694	882	\$642	29	28	27	11	17
National Capital Area	216,001	5,756	2,796	308	701	12	12	13	2	10
Baltimore Metro Area	226,161	6,250	3,137	365	620	47	43	37	12	31
Eastern Shore	42,221	1,111	570	70	600	53	51	50	37	11
Southern Maryland	33,863	946	475	57	599	32	33	40	18	11
Western Maryland	47,629	1,317	716	82	580	23	20	22	15	7
HMO Plans, Capitated Services										
Total	-----	3,360	5,408	694	-----	-----	-37	-16	-17	-----
National Capital Area	-----	1,574	2,823	327	-----	-----	-20	-7	-11	-----
Baltimore Metro Area	-----	1,293	1,783	251	-----	-----	-47	-25	-20	-----
Eastern Shore	-----	115	211	34	-----	-----	-63	-36	-33	-----
Southern Maryland	-----	187	304	40	-----	-----	-42	-19	-20	-----
Western Maryland	-----	192	288	42	-----	-----	-32	-16	-16	-----
All Plans, All Services										
Total	-----	48,614	32,284	2,449	-----	-----	12	8	3	-----
National Capital Area	-----	12,814	9,079	706	-----	-----	9	5	1	-----
Baltimore Metro Area	-----	25,910	16,764	1,225	-----	-----	15	10	4	-----
Eastern Shore	-----	3,135	1,961	164	-----	-----	14	8	2	-----
Southern Maryland	-----	2,873	1,924	146	-----	-----	6	5	0	-----
Western Maryland	-----	3,882	2,556	208	-----	-----	7	7	2	-----
Note: A "-----" means not applicable. Count of HMO persons served is based on unique patient identifiers separately for individuals with fee-for-service (FFS) claims and capitated encounter data. Total number of users is less than the sum of the individual plan type user counts because most HMO patients with capitated services also receive HMO FFS services. Various edits of the database exclude about 15 percent of spending from the data shown in this table. One large non-HMO payer was excluded from this analysis due to substantial changes in the form and content of data submitted for 2002. Reported spending growth for HMO plans may be strongly affected by the shift from capitated to FFS arrangements. Source: Analysis of 10 percent sample of persons, Maryland MCDB 2001-2002.										

that do not reflect full payment for services. The table shows both payment and RVUs for services paid on a fee-for-service basis, and RVUs only for services paid on a capitated basis. All payers and services that passed routine data quality edits are included in this table.

For the non-HMO plans, spending grew 18 percent, reported users of care increased 8 percent, and payments per user increased 9 percent.¹¹ The high growth in reported users is largely a reflection of the increased enrollment in these plans in 2002, as Maryland enrollment continued to shift from HMO to non-HMO plans, although some of the increase is attributable to a higher fraction of enrollees using health care. As noted above, for HMO plans, the high reported spending and volume growth is an artifact of changes in data reporting and substantially overstates true growth in service use for those plans.

The growth rates by region are difficult to interpret due to changes in the composition of the insurance markets. For the non-HMO plans, the influx of former HMO enrollees varies by region. For the HMO plans, the shift from capitation to fee-for-service payment clearly results in large regional differences in reported volume growth. Regions with the largest reductions in capitation show the largest gains in fee-for-service payment due to the more complete reporting of services under fee-for-service arrangements.

The lower portion of Table 2-1 shows volume of care for all insurers and all modes of payment. In total, reported RVUs of care grew 12 percent, while the total number of services increased 8 percent.

SPENDING TRENDS IN NON-HMO PLANS

This section looks in detail at spending trends for non-HMO plans from 2001 to 2002, examining trends by type and place of service, practitioner specialty, and other factors. In each table in this section, the two left-most columns show spending and share of 2002 total spending, while the three right columns show growth in total spending divided into change in prices (payment per RVU) and quantity (total RVUs of care). Results are described below the tables.

Total and by Region. In aggregate, practitioner spending for non-HMO plans rose about 18 percent. Spending growth was highest in the urbanized areas of the State (National Capital Area and Baltimore Metro Area), and lower in the more rural parts of Maryland (Eastern Shore, Southern and Western Maryland). In aggregate, there was a 2.7 percent increase in average fees (payment per RVU of care), rounded to 3 percent in Table 2-2. This is a substantial break from prior years, where fees fell slightly from 1999 to 2001.

¹¹ As noted in the methods section, the count of users may be subject to some uncertainty. Percentage changes in these tables will not exactly sum to the change in spending due to rounding, and because the changes should be multiplied (not added) to arrive at total spending.

Table 2-2: Spending Growth in Non-HMO Plans, 2001-2002

Classification	2002 Data		Percent Change, 2001-2002		
	Payments (\$millions)	Percent of Payments	Total Payments	Price (Payment per RVU)	Quantity (RVUs)
Total	\$1,142	100%	18%	3%	15%
Region					
National Capital Area	\$234	20	18	1	17
Baltimore Metro Area	675	59	21	3	17
Eastern Shore	74	6	14	1	12
Southern Maryland	66	6	10	7	3
Western Maryland	93	8	8	2	5
Place of Service					
Inpatient	\$131	12	11	-1	12
Office	738	65	22	4	17
Other	94	8	14	1	14
Outpatient	179	16	11	2	9
Coverage Type					
Individual Plan	\$73	6	24	-1	25
Employer-Self-funded	434	38	19	1	18
Employer-Insured	135	12	23	3	19
Public Employee	346	30	15	5	10
CSHBP	150	13	16	3	13
Taft-Hartley Trust	6	0	26	-3	30
Type of Service					
Evaluation/Management	\$469	41	21	6	13
Procedures	306	27	8	1	7
Imaging	171	15	23	0	22
Tests	113	10	12	0	12
Childhood Immunizations	7	1	13	7	6
Other/not grouped	76	7	59	4	53
Physician Participation Status					
Participating	\$948	87	18	2	15
Nonparticipating	144	13	24	0	24
Note: Small categories and missing services are omitted from some categories. CSHBP is Comprehensive Standard Health Benefit Plan. Detail may not add to totals due to omitted "miscellaneous" categories and due to rounding. The "Other" place of service includes errors and omissions in place-of-service coding and should be ignored.					

Place of service. As was true last year, spending and service use grew more rapidly in physicians' offices than in other identified settings. This year, a 4.4 percent increase in fee levels (rounded to 4 percent in the table) contributed significantly to the payment increase in the office setting, in addition to the 17 percent growth in RVUs of care. In contrast to last year's report, the hospital outpatient department (OPD) was not the fastest-growing site of care this year. In 2001, RVUs of care in OPDs grew 15 percent, but that slowed to 9 percent in 2002. (The "other" place of service largely reflects errors or omissions in place-of-service coding and should be ignored.)

Coverage type. From 2001 to 2002, among those with employer-sponsored coverage, there appeared to be a small shift away from self-insured toward fully-insured coverage. This is similar to the small shift observed in last year's Practitioner Report. Individually-purchased health insurance plans and Taft-Hartley Trust plans showed the highest rates of volume growth. Spending growth in Comprehensive Standard Health Benefit Plan (CSHBP) products was similar to the overall market rate in 2002. In the two previous years, spending under CSHBP had grown more rapidly than the overall market, consistent with enrollment growth reported in the surveys of CSHBP insurers conducted by the MHCC.

Aggregate type of service. The most interesting feature of the growth by type of service is that the use of procedures accounted for little of the overall volume or spending growth. This was due to a very low growth in major surgical procedures, and modest growth in ambulatory procedures. Beyond that, growth was broadly based among the other identified types of care. The distribution of payment across the services was essentially unchanged from 2001.

Participation status. There was a modest decline in the fraction of spending for participating physicians in 2002 compared to 2001, driven by an increase in the use of out-of-network practitioners in excess of the growth in services provided by participating practitioners. This change does not appear significant, as the situation in 2001 was the reverse, with the 2001 participation rate somewhat above the rate for 2000.

Specialty. Table 2-3 shows spending growth by practitioner specialty for all identifiable specialties accounting for at least 1 percent of spending in 2002. While these data may not be reliable for very small categories of physician specialties, some broad patterns are clear. Spending growth for surgeons (3 percent) was far lower than spending growth for other types of physicians. Not only was growth in RVUs low for surgeons, the payment per RVU rose for medical specialties but not for surgeons. These facts are consistent with data showing slow growth in major procedures and increased payment for office visits in 2002 (Table 2-4). Nonphysician practitioners (defined here to include independent laboratories) accounted for 18 percent of practitioner spending. That proportion is unchanged from 2001. Spending growth for these practitioners was below that of physicians both because the growth in RVUs was slower, and because payment per RVU fell slightly.

Table 2-3: Spending Growth by Practitioner Specialty, Non-HMO Plans, 2001-2002

Classification	2002 Data		Percent Change, 2001-2002		
	Payments (\$millions)	Percent of Payments	Total Payments	Price (payment per RVU)	Quantity (RVUs)
Nonphysician Practitioners	\$200	18%	15%	-1%	16%
Independent Laboratory	57	5	5	0	5
Chiropractor	33	3	16	-1	18
Physical Therapist	32	3	19	0	18
Psychologist	14	1	16	-5	21
Podiatrist	12	1	6	2	4
Physicians, Total	\$783	69	21	2	19
Physicians, Medical Specialties	433	38	25	4	21
Internal Medicine	91	8	24	5	18
Pediatrics	64	6	21	9	11
Family and General Practice	60	5	10	2	8
Cardiology	43	4	30	-1	31
Emergency Medicine	27	2	21	2	19
Oncology	24	2	81	-2	84
Gastroenterology	24	2	19	1	18
Dermatology	23	2	18	3	14
Neurology	18	2	48	5	41
Psychiatry	14	1	31	3	28
Physicians, Other Specialties	219	19	25	0	25
Radiology	114	10	34	-1	36
Obstetrics/Gynecology	83	7	13	2	11
Pathology	21	2	29	-9	41
Physicians, Surgical	130	11	3	0	3
Orthopedic Surgery	40	4	8	3	5
General Surgery	24	2	-8	-1	-7
Ophthalmology	20	2	4	-5	9
Otology/Laryngo/Rhino/Otolaryngology	16	1	4	1	3
Urology	15	1	18	3	14

Notes: Practitioners whose specialty could not be uniquely determined (including "clinic," "multispecialty practice," and miscellaneous or missing specialty) accounted for 14 percent of spending. These practitioners are omitted from this table. Specialties accounting for less than 1 percent of spending are not shown. Detail may not add to totals due to rounding. The large reported growth for oncologists may reflect redefinition of related specialties (oncology, hematology, and oncology subspecialties) by payers between 2001 and 2002.

Table 2-4 shows spending by detailed type-of-service categories.¹² Looking across categories of service, some interesting features are the slow growth of major procedures yet high growth in spending for hospital-based evaluation and management services (visits), and the large fee increase for office visits. First, for major procedures, most payers showed relatively slow growth, and growth in this category was slow last year as well. These factors suggest that the low growth in major procedures reflects ongoing

¹² The categories shown here are aggregations of Medicare's Berenson-Eggers Type of Service (BETOS) categories. The categories of visits refer only to evaluation and management services, and do not include other procedures that might be performed in the course of an office or hospital visit.

changes in the practice of medicine, for example, substituting minimally invasive outpatient surgeries for traditional open surgeries.

Table 2-4: Spending Growth by Detailed Type of Service, Non-HMO Plans, 2001-2002

Category	2002 Data		Percent Change, 2001-2002		
	Payments (\$millions)	Percent of Payments	Total Payments	Price (payment per RVU)	Quantity (RVUs)
Total	\$1,142	100%	18%	3%	15%
Visits, Office	266	23	21	11	9
Visits, Specialty (Consults, Psychiatry, Other)	144	13	19	0	19
Visits, Hospital/Nursing Home/Home	31	3	29	-3	32
Visits, Emergency Room	28	2	21	5	16
Procedures, Major	100	9	3	0	4
Procedures, Minor/Ambulatory	161	14	11	2	9
Procedures, Endoscopies	45	4	6	0	6
Imaging, Standard (Xray)	56	5	23	3	19
Imaging, Advanced/Procedure (CAT, MRI, Cardiac)	74	7	25	-1	26
Imaging, Echography	41	4	19	-1	20
Tests, Automated General Profile Lab Tests	15	1	8	-4	12
Tests, Other Lab Tests	68	6	12	2	10
Tests, Other (EKG, Stress Test, other)	30	3	15	0	16
Childhood Immunizations	7	1	13	7	6
Miscellaneous and Not Grouped	76	7	59	4	53
Notes: Growth rates for emergency room visits were calculated excluding one major payer due to failure to report these visits in 2002. See text for explanation of increased hospital visits. Detail may not add to totals due to rounding.					

Second, for hospital inpatient evaluation and management services, a more detailed look at the data shows that the main driver of increased RVUs was a greater intensity of billing per hospitalized person, particularly for neonatal intensive care services. RVUs for a physician's initial visit with a hospitalized patient increased 14 percent, roughly in line with enrollment changes and with the number of hospitalized individuals in non-HMO plans. RVUs for physicians' additional (subsequent) hospital visits with a patient increased 23 percent. RVUs for critical care visits increased 73 percent, and three-quarters of that increase was due to increased billing for neonatal intensive care. Scanning the entire database, across all payers (HMO and non-HMO) we found a significant increase in the number of privately insured infants using critical care services, due at least in part to a shift of such care from HMO to non-HMO plans between 2001 and 2002. Because this is a rare but costly service, and because there was a clear shift of care among plan types, we suspect that the reported increase in use was due, in part, to changes in some payers' billing arrangements, not to a true rapid increase in infants requiring critical care services.

Finally, the large increase in office visit fees was primarily due to substantially increased payment rates by one of the larger insurers. Most insurers gave modest rate increases for office visits, but one insurer had double-digit increases in rates. This increased the payment per RVU for office visits by 11 percent, averaged across all non-HMO insurers.¹³

VOLUME OF SERVICE GROWTH IN HMO PLANS

The MHCC estimates that overall enrollment in HMOs declined about 7 percent from 2001 to 2002.¹⁴ From the standpoint of tracking services use, however, changes in HMO provider payment arrangements more than offset this decline. HMOs reduced the use of capitation as a method of provider payment by over one-third between 2001 and 2002, as measured by RVU volume (Table 2-1).¹⁵ The substitution of fee-for-service billing for capitation arrangements increases the total amount of care that is reported in the MCDB because capitated primary care services do not have to be reported to the MCDB. Accordingly, the volume growth for 2002, as reported in the MCDB, will overstate the true volume increase for HMOs for this year (Table 2-5). Ongoing improvements in HMO data reporting may further increase the reported growth rates shown in this section.

Region. The reported HMO service data show large differences in growth of volume of service across regions. These differences may reflect a variety of factors, including true differences in volume growth, changes in enrollment, the switch from capitation to fee-for-service payment, and the underlying volatility of the HMO market during a time of declining market share. Given the relatively large influence that these factors might have, it is difficult to interpret the regional data with any confidence. Overall growth in RVUs of care was 8 percent. The pattern of reported growth was highly uneven across regions of Maryland.

Place of Service. As with the non-HMO plans, the HMOs showed the lowest volume growth in the hospital outpatient setting and the highest growth in physicians' offices. (The "other" place of service largely reflects errors or omissions in place-of-service coding and should be ignored.)

¹³ This analysis uses 2002 RVUs throughout, for measuring both the 2001 and 2002 data. Medicare's RVU values for office visits increased about 6 percent in 2002. To the extent that payers set their own fees as some multiple of the Medicare rates within service category (a common practice), this would have resulted in increased private rates for visits in 2002 independent of any additional actions payers may have taken.

¹⁴ Maryland Health Care Commission, *State Health Care Expenditures: Experience from 2002*, (Baltimore, MD: MHCC, January 2004).

¹⁵ The most significant change was that CareFirst launched a new HMO product, BlueChoice, in late 2001 that replaced several CareFirst offerings. BlueChoice principally reimburses physicians via fee-for-service payments, and this change reduced the use of capitation and increased the volume of data submitted to MHCC for 2002.

Coverage type. Trends in HMO service use by coverage type are the mirror image of the trends for the non-HMO plans, except for State employees. Among those with employer-sponsored coverage, growth was highest for employer self-insured plans and lower for fully insured products and public employees. Small group and individual purchase insurance showed large declines in volume of care. Data reported for the CSHBP products, in particular, declined sharply in comparison to last year. Other information for the CSHBP, by contrast, suggests that total HMO enrollment (including point of service options) was essentially unchanged from 2001 to 2002.¹⁶ Premiums in the small group market for HMOs and non-HMOs are similar because high deductible non-HMO products must be offered.¹⁷ This suggests that the large reported decline in CSHBP HMO utilization over the last 2 years may reflect changes in payers' data reporting practices.

Aggregate type of service. The HMO data by type of service show highest growth for imaging care, and lower growth for other types of services. This is a complete turnaround from the prior year's data, where tests showed the highest rate of growth and imaging services had one of the lowest.¹⁸

Participation status. Services of participating physicians grew faster than services performed by nonparticipating physicians. The share of care delivered by participating physicians (95 percent) is somewhat higher than in the previous year (93 percent).

¹⁶ Maryland Health Care Commission, *Annual Review, Comprehensive Standard Health Benefit Plan for Year Ending December 31, 2002*, (Baltimore, MD: MHCC, October 2003).

¹⁷ MHCC, *ibid.*

¹⁸ For the most part, the type-of-service distribution in this table cannot be directly compared to the distribution published last year. In prior years, clinical laboratory tests were excluded from this table due to problems in data reporting. This year those tests are included, greatly increasing the share of RVUs attributed to tests, and reducing share for other services. Absent that change, the distribution of RVUs by type of service this year would appear similar to the distribution shown last year.

Table 2-5: Volume Growth in HMO Plans, 2001-2002

	RVU (000s)	Percent of Total	Percent Change 2001-2002
Total	18,739	100%	8%
Region			
National Capital Area	7,329	39	3
Baltimore Metro Area	7,543	40	10
Eastern Shore	1,226	7	17
Southern Maryland	1,133	6	10
Western Maryland	1,509	8	9
Place of Service			
Inpatient	1,996	11	5
Office	12,632	67	8
Other	2,260	12	15
Outpatient	1,851	10	2
Coverage Type			
Individual Plan	406	2	-35
Employer-Self-funded	4,272	23	29
Employer-Insured	6,763	36	9
Public Employee	4,811	26	10
CSHBP	2,239	12	-17
Type of Service			
Evaluation/Management	7,938	42	3
Procedures	4,481	24	13
Imaging	2,591	14	34
Tests	2,228	12	1
Childhood Immunizations	180	1	1
Other/not grouped	1,321	7	-7
Physician Participation Status			
Participating	17,860	95	9
Nonparticipating	834	4	-7
Notes: Reduced use of capitation in 2002 results in some overstatement of growth rates in this table. Detail may not add to totals due to rounding, and to omission of some small miscellaneous categories. Prior year tables excluded clinical laboratory tests due to data reporting issues, but clinical laboratory tests are included in this table.			

3. Payment Rates in Private Plans and Medicare

This section of the report compares private payers' fees to the fees paid by Medicare, and tracks trends in private payers' fees over time.¹⁹ Medicare's resource-based fee schedule provides a uniform framework for comparing the average level of Medicare and private practitioner fees, both regionally and by type of service.

The Medicare program provides a convenient national and local reference for prices for practitioners' services. Medicare is a large purchaser of practitioners' services in all geographic areas, and accounts for between one-quarter and one-half of revenue for most specialties.²⁰ Medicare's fees are public information and have become the most common benchmark against which private payers' fees are compared.

The 1999-2000 Practitioner Report summarized the existing studies comparing Medicare and private payers' physician fees. On average, for the nation as a whole, Medicare's rates have historically been significantly lower than the average private payers' rates. This varies by region (higher or lower across States), by type of service (Medicare rates are higher for office visits and similar services, lower for procedures and tests), and by payer (HMOs tend to have lower rates than other private payers, on average).

Practitioner Reports from the last few years have shown that private fees in Maryland have been relatively stable, while Medicare fees have varied from year to year due to large positive and negative annual Medicare fee updates. In all years from 1999 forward, private rates in Maryland were near the Medicare level on average, although the gap between Medicare and private fees varies considerably by type of service.

This pattern continues through 2002. Using a slightly different method than was used in prior years, fees paid by HMOs averaged about 2.7 percent below the Medicare level,

¹⁹ Throughout this report, the terms "fee," "price," and "payment per service" mean the total payment physicians receive for care, including payments from the insurer and any deductible, coinsurance, and balance billing amounts (for nonparticipating physicians) paid directly by the patient.

²⁰ Medicare's share of practice revenue is substantially below 25 percent only for obstetrics, pediatrics, and psychiatry. See *Physician Marketplace Statistics 1997/1998*, ML Gonzalez and P Zhang, Editors (Chicago, IL: American Medical Association Center for Health Policy Research, 1998).

while fees paid by the non-HMO plans were about 2.7 percent above the Medicare level.²¹ As in prior years, Maryland private rates remain near the Medicare level on average.

When private rates are examined over time without reference to Medicare's fees, it is clear that payment rates were roughly stable, on average, through 2001. But fees began to rise for both HMO and non-HMO payers starting in 2002 and continuing into the first part of 2003, due largely to increased fees for office visits.

PAYMENT RATES

Table 3-1 shows the difference between private fee levels and Medicare rates for 2002, for both non-HMO plans and the fee-for-service claims of HMO plans. The analysis of prices produces several interesting findings.

First, averaged across all areas and claims, private payers in Maryland paid practitioner fees that were, in 2002, quite close to the typical Medicare rate. Fee-for-service payments of HMOs were slightly below the Medicare rate, on average, while payments from non-HMO plans averaged slightly above Medicare (Table 3-1). The small differences between average HMO and non-HMO rates, and between private and Medicare rates in Maryland are both consistent with findings from earlier Practitioner Reports.

Across the regions, the non-HMO plans pay their highest rates in the National Capital Area and lowest rates in the Baltimore Area, with all other Maryland regions falling between these extremes. HMO plans, by contrast, have a much narrower differential between the National Capital Area and the Baltimore Metro Area. Their highest rates are paid on the Eastern Shore, and lowest rates are paid in Southern Maryland.

Payers' rates in the regions of Maryland reflect the supply of physicians, competition among plans, and other market forces that are difficult to quantify. The Medicare program, by contrast, sets rates across regions that are in proportion to a measure of the cost of inputs to medical practice across regions. These rates are adjusted by geographic factors that reflect differences in input costs across the country. A composite measure of all factors, the Medicare Geographic Adjustment Factor (GAF), shows how the National Capital Area, the Baltimore Area, and the rest of Maryland compare to the U.S. average in terms of costs. Based on Medicare's estimates, costs in the National Capital

²¹ There was a small change in the methodology this year compared to previous years. This year, the exact private-payer service mix was used to compute the Medicare rate in each category, using prices calculated from

Area are 9.5 percent above the U.S. average, in Baltimore they are 2.5 percent above the U.S. average, and costs in the rest of Maryland are 2.8 percent below the U.S. average.²²

Table 3-1: Payment Rates for Private Non-HMO and HMO Fee-for-Service Claims versus Medicare, 2002

	Non-HMO Plans				HMO Plans			
	Payment per RVU Using Medicare Rates	% of Payments	Payment per RVU	% Diff from Medicare	Payment per RVU Using Medicare Rates	% of Payments	Payment per RVU	% Diff from Medicare
Total	\$37.25	100%	\$38.24	2.7%	\$37.82	100%	\$36.80	-2.7%
Region								
National Capital Area	\$39.10	20	\$42.67	9.1	\$39.37	38	\$37.53	-4.7
Baltimore Metro Area	37.12	59	36.77	-0.9	37.32	40	36.19	-3.0
Eastern Shore	35.89	6	38.70	7.9	35.83	7	38.00	6.1
Southern Maryland	36.36	6	38.11	4.8	36.55	6	35.81	-2.0
Western Maryland	35.75	8	39.11	9.4	35.99	8	36.17	0.5
Type of Service								
Evaluation and Management	\$37.34	41	\$34.68	-7.1	\$37.81	41	\$33.21	-12.2
Procedures	37.17	27	43.94	18.2	37.67	30	40.80	8.3
Imaging	37.53	15	40.29	7.4	38.30	15	38.06	-0.6
Tests	36.64	10	41.91	14.4	37.41	6	44.12	17.9
Childhood Immunizations	37.45	1	45.50	21.5	37.78	1	39.91	5.6
Other/Not Grouped	37.16	7	33.35	-10.3	37.69	7	36.55	-3.0
Place of Service								
Inpatient	\$37.07	12	\$48.31	30.3	\$37.50	16	\$46.11	23.0
Office	37.35	65	34.71	-7.1	37.98	63	33.21	-12.6
Other	37.19	8	42.68	14.8	37.45	7	37.85	1.1
Outpatient	36.86	16	48.51	31.6	37.37	14	47.86	28.1
Physician Participation								
Participating	\$37.21	87	\$36.16	-2.8	\$37.83	92	\$35.92	-5.0
Nonparticipating	37.58	13	59.21	57.6	37.63	7	51.90	37.9
Note: Calculation method is slightly different from that used in prior reports, so numbers are not exactly comparable to data from prior reports. Detail may not add to total due to rounding and omission of small "miscellaneous" categories.								

Different pricing strategies by HMO and non-HMO plans, as well as a different mix of payers, can lead to significant regional variations in the gap between Medicare and private sector payment rates. The National Capital Area exhibited the greatest deviation from Medicare rates with non-HMOs paying about 9 percent above Medicare rates

Medicare fee schedule and geographic practice cost index information. Compared to last year's report, this method shows Medicare rates that are about 2 percent higher, overall, than were shown last year.

²² Source: Addenda E and F, HCFA, *Federal Register*, November 1, 2000.

(on average), while fee-for-service payments by HMOs are about 5 percent below the Medicare rates (on average).²³ Both types of payers appear to pay relatively well on the Eastern Shore. In the Baltimore region, private HMO and non-HMO rates are modestly below average Medicare rates. Rates paid by non-HMOs in Western and Southern Maryland are moderately to significantly above Medicare rates (on average), but HMO rates are equivalent or modestly lower than Medicare rates. The difference in the rates paid by non-HMOs and HMOs in the National Capital Area highlights the fact that different payers dominate each delivery system in that region.

By type of service, HMO and non-HMO plans tend to have similar pricing structures. Both pay less than Medicare for evaluation and management (visit) services, and generally pay modestly more for other types of care. As was the case last year, the HMO plans appear to pay much less for childhood vaccines than do the non-HMO plans.

Finally, the data by participation status show that HMO and non-HMO rates are much closer for participating physicians than for out-of-network physicians. For participating physicians, non-HMO plans pay 2.8 percent less than Medicare, while HMO plans pay 5 percent less than Medicare, on average. The major difference in payment comes from payment to nonparticipating (out-of-network) physicians. For non-HMO plans, nonparticipating physicians account for 13 percent of payments, and are paid about 60 percent above the Medicare level. For HMO plans, nonparticipating physicians account for just 7 percent of payment, and rates average about 40 percent above the Medicare level. Thus, most of the difference between average HMO and non-HMO payment rates is attributable to the higher payment rates and larger fraction of payments made to nonparticipating physicians by non-HMO plans.

These calculations all rely on the Medicare program's RVUs as the basis for comparison. Changes in RVUs across years may modestly affect the results of this price measurement. That is, resulting estimates reflect not only the change in private payers' fees, but also, to a lesser degree, changes in Medicare's RVUs.

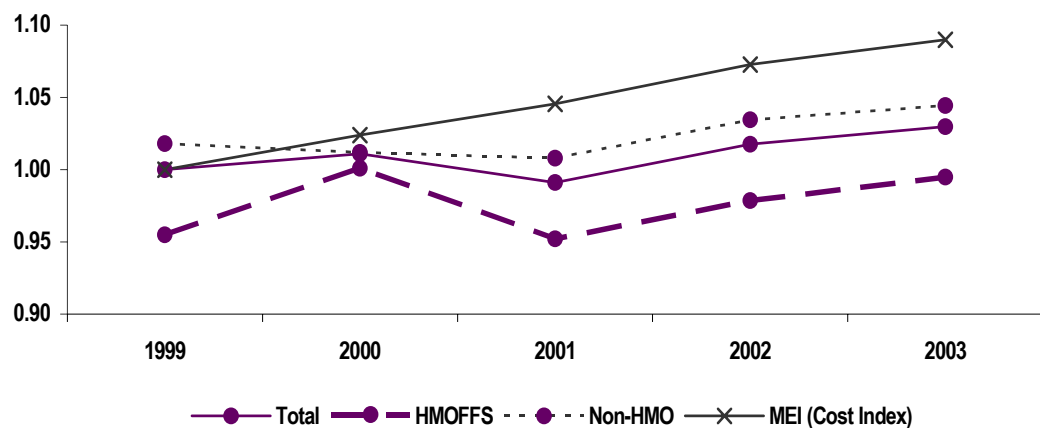
An alternative way to track changes in average private rates is a private-payer price index. The method for constructing the index is similar to the method used to construct the United States Consumer Price Index. Setting average private fees in 1999 at 1.0 (for the weighted average of HMO fee-for-service payments and non-HMO payments), we can track changes in the average payment level, where each service is weighted in proportion to typical private use rates for the service. Compared to the Medicare analysis, this gives

²³ Non-HMO data for one major payer in the National Capital Area was dropped due to data problems in 2002. Including that payer's records in the 2002 data would have reduced the non-HMO private-to-Medicare difference by about 2 percentage points below what is shown in Table 3-1 for the National Capital Area.

a more accurate accounting of private price changes, and it ignores annual changes in Medicare's RVUs and conversion factors.

Based on this analysis, average private fees began to rise in 2002, and continued to rise through early 2003. As of April 2003, the price index stood at 1.03, or 3 percent higher than it had been in 1999 (the base year). The average private rate fell slightly from 1999 to 2001, but that decline was more than offset by the increases that occurred from 2001 to April 2003 (Figure 3-1). For comparison, Figure 3-1 also shows the increase in the Medicare Economic Index (MEI), which is Medicare's estimate of the average increase of the costs of running a physician practice. The cumulative increase in private payers' fees since 1999 is well below the roughly 9 percent increase in costs over the 1999 to 2003 period.

**Figure 3-1: Index of Private Payment Rates and Physician Costs, 1999-April 2003
(1999 all private plans = 1.00)**



HOW DO MARYLAND PRIVATE INSURANCE FEES COMPARE TO PRIVATE INSURERS' FEES ELSEWHERE?

This section of the report summarizes some nationally representative surveys of private payers' rates, using the results to place the average Maryland private insurers' fee level in the context of rates paid nationwide. Based on available information, Maryland private insurers' practitioner fees are significantly below the national average, and Maryland appears to rank below the 25th percentile of states in terms of the level of private rates relative to Medicare.

Two studies commissioned by the Medicare Payment Advisory Commission (MedPAC) suggest that in 2001, private payers' rates nationwide averaged roughly 20 percent above

Medicare's 2001 rates.²⁴ Although the studies used different approaches (plan survey versus analysis of large claims databases), the estimated fee levels were substantially in agreement. Because Medicare rates were reduced several percentage points in 2002, private fees in 2002 are probably somewhat more than 20 percent above Medicare rates, on average.

In Maryland, by contrast, private insurers' fees are roughly on par with Medicare rates, on average, and have been for at least the last several years. The contrast between the MedPAC findings nationwide and the results shown here strongly suggest that private rates in Maryland are lower, compared to Medicare, than are private rates in the United States as a whole.

It is difficult to determine exactly where Maryland falls among the states in terms of private fee levels, but two sources of data suggest that Maryland ranks around the 20th to 25th percentile of States in terms of the level of its private insurance rates for physicians and other practitioners. First, one of the MedPAC-sponsored studies shows that for health care plans of all types, about 25 percent of plans have fees that are below the Medicare level on average.²⁵ Roughly speaking, this suggests that Maryland average private plan rates would rank somewhere around the 25th percentile of all private plans' rates.

Second, a recent study of HMO plans also places Maryland rates near the 25th percentile of all states, in terms of physician payment rates by HMO plans. Among 22 states with adequate numbers of survey responses to allow mean payment levels to be estimated, only four states had HMO rates below the Medicare level. (These were California, Arizona, Florida, and New Jersey).²⁶ Unfortunately, that survey did not have adequate responses from Maryland. But, if the estimated 2001 Maryland HMO fee-for-service rate level was included in that distribution, Maryland would fall at the 22nd percentile of all states.

Several factors, including location, physician supply, and HMO penetration, may explain why Maryland payment rates are below the national average. One of the MedPAC-sponsored studies cited above identified factors associated with variation in payment

²⁴ These studies are summarized in *Medicare and Private Payers Payment Rates to Physicians*, (Washington, DC: MedPAC, August 2003). Accessible at

http://www.medpac.gov/publications/contractor_reports/Aug03_PhysPayRptsSumry.pdf

²⁵ See Exhibit 16 page 24, in Dyckman, Z, P Hess, *Survey of Health Plans Concerning Physician Fees and Payment Methodology* (Washington, DC: Dyckman and Associates, June 2003). This report may be accessed from the MedPAC website www.medpac.gov.

²⁶ Milliman USA, 2001 HMO Intercompany Rate Survey (Brookfield, WI: Milliman USA, 2001).

rates.²⁷ First, the gap between Medicare and private rates was smallest for the Northeast Census region and for urbanized areas, and Maryland is adjacent to these Northeast states with relatively low private payment rates relative to Medicare. Second, obtaining adequate physician participation is the next most important factor driving plans' fee update decisions.²⁸ A large supply of physicians makes it easier for plans to provide enrollees with adequate access to physician care. Maryland ranks third in the nation in terms of physicians per capita, with 38 percent above the U.S. average.²⁹

A third factor that may contribute to lower fee levels in Maryland is the share of the population in managed care. Because HMOs tend to pay lower fees than other types of plans, managed care penetration tends to reduce the average level of practitioner fees. In addition, managed care is associated with lower overall premiums, with high managed-care penetration forcing other types of plans to constrain cost growth to be able to offer premiums competitive with HMO premiums.³⁰ High managed-care penetration would be expected to reduce fees, and Maryland ranks about 9th in the nation in terms of total HMO market penetration.³¹

Given this context, Maryland's relatively low practitioner payment rates appear to be a normal consequence of market forces within Maryland. Location near the Northeast states (where fee levels appear lowest), a large supply of physicians, and moderately high HMO penetration are all factors that work to produce lower fees in Maryland than in the United States as a whole.

INFORMATION ON CURRENT ISSUES

The Maryland Health Care Commission and the Health Services Cost Review Commission have been directed by the legislature to examine the adequacy of physician payments by private payers and the equity of private payer payment policies to nonphysician providers. The Commissions were also directed to recommend whether current law pertaining to balance billing should be maintained. In January 2004, the two Commissions issued a joint report addressing these and other issues related to practitioner payment. A major portion of this section summarizes some of the key results from that report concerning the level of practitioner payment and the impact of

²⁷ Dyckman and Hess, *ibid.*

²⁸ Dyckman and Hess, *ibid.*, Exhibit 14, page 18

²⁹ U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, State Health Workforce Profiles Highlights – Maryland. (Rockville, MD: USDHHS/HRSA/BHPr, 2000). Accessible at <http://www.hrsa.gov/bhpr/workforceprofiles/maryland.pdf>

³⁰ Baker LC, Cantor JC, Long SH, Marquis MS., "HMO market penetration and costs of employer-sponsored health plans", *Health Affairs* 2000 Sep-Oct;19(5):121-8.

³¹ See State rankings of 2002 HMO penetration rates compiled by Interstudy and published by the Kaiser Family Foundation State Health Facts accessible at <http://www.statehealthfacts.org>.

the 125 percent fee screen. The first analysis in this section approximates a 125 percent payment threshold, based on average payments by payer, region, and service. This shows the extent to which HMOs appear to be complying with the minimum payment standards for nonparticipating physicians. The second analysis looks at the existing payment differential between physician and nonphysician practitioners, for the highest-volume nonphysician practitioner specialties and for a few services relevant to each nonphysician specialty. This analysis shows whether current payment differences appear large enough to warrant legislative interest in this issue.

The final portion of this section examines the out-of-pocket payment shares across coverage categories. This particular issue has relevance to policymakers, because the MHCC and Maryland Insurance Administration have joint authority to administer the CSHBP, a State program that enables small businesses in the State to purchase private coverage at affordable rates. Recent increases in health care premiums have required the MHCC to increase the affordability of the package, principally by increasing patient cost sharing. The analysis allows MHCC and other policymakers to compare out-of-pocket shares across group and individual market products.

HMO payment to nonparticipating physicians.³² Under Maryland law, providers under contract with HMOs (participating providers), as well as nonparticipating providers, may not balance bill HMO members or subscribers for covered services. This prohibition limits the ability of nonparticipating providers to negotiate with HMO patients on fees at the time of service as they could do in a free market situation. The Maryland legislature has sought to balance this restriction by requiring that the rate paid for any service provided by a nonparticipating provider must at least equal 125 percent of the in-network rate for that service.

Overall, HMO services by nonparticipating practitioners account for a relatively minor share of all private insurance payments to practitioners. HMO payments to nonparticipating physicians account for only 2 percent of all fee-for-service physician services. The proportion of care delivered by nonparticipating physicians varies widely by type of service. At the extreme, about 15 percent of all emergency room services are provided by nonparticipating providers, but the HMO services provided by nonparticipating physicians constitute only about 7 percent of all emergency department services (data not shown).³³ These results imply that the impact on providers is relatively small. For HMO patients, a somewhat different picture emerges. About 6 percent of all

³² A proposal introduced in the 2004 Session of the Maryland legislature would repeal the Maryland law that prohibits noncontracting Maryland providers from balance billing patients, however the bill was withdrawn prior to vote.

³³ Based on MHCC analysis of the 2002 HSCRC emergency department data.

HMO fee-for-service practitioner services are delivered by nonparticipating providers (Table 3-2). That figure jumps to 33 percent of all HMO fee-for-service emergency department services. So the likelihood that an HMO enrollee will see a nonparticipating physician is more substantial. Up to one-third of HMO patients in some care settings could be seen by a nonparticipating provider.

To estimate the compliance with the current standard, records submitted by HMOs for fee-for-service payments were extracted and separated for participating and nonparticipating physicians. Mean payment rates for participating and nonparticipating physicians were calculated by payer and region of the state. In calculating the participating physician payment averages, we omitted any cases where fewer than 10 bills for participating physicians were available for a given insurance plan, region of the state, and service because averages for small samples are often unreliable. Rates for participating and nonparticipating physicians were matched by plan, region, and service. We identified bills where the payment to the nonparticipating provider was above 125 percent of the average payment to the participating providers. If a payer reimbursed a nonparticipating physician at the physician's billed charge, the service was also considered in compliance with the law.³⁴

Nonparticipating HMO bills were concentrated in just a few categories, with emergency department visits being the most frequent (Table 3-2). Patterns of apparent compliance in 2002 were similar to those shown in 2000, with somewhat less than half of HMO nonparticipating bills appearing to exceed the 125 percent threshold. In short, there appears to have been essentially no change from 2000 to 2002 in the fraction of bills complying with the regulation, using a definition of the in-network rate as being equal to the average payment across all contracting physicians for the service.

This simple count of bills that do not meet the threshold may give an incorrect impression of the amount of payment involved in meeting the threshold. Rather than counting bills, we could have asked how much higher the total payment on these nonparticipating bills would have been if each bill had met or exceeded the threshold. For example, even though 78 percent of emergency visit bills failed to meet the threshold, if all bills had met the threshold amount, total payment amount on these nonparticipating emergency visit bills would have risen only 9 percent. This occurs because even when payments do not literally exceed the threshold amount, they are typically not far from it. This points to the possibility that some payers may define the in-network rate using a particular set of contracted rates that are below the overall

³⁴ A large HMO reports that it reimburses nonparticipating providers' billed charges.

average.³⁵ A more detailed analysis is presented in the joint MHCC-HSCRC report on this topic.³⁶

Table 3-2: Estimated Fraction of HMO Bills to Nonparticipating Physicians Meeting 125 Percent Threshold, by Type of Service, 2000 and 2002³⁷

	Percent Exceeding Threshold		2002 HMO Nonparticipating Physician Bills			
	2000	2002	Number	Percent of All HMO Nonparticipating Bills	HMO Nonparticipating Bills as Percent of HMO FFS Bills	HMO Nonparticipating Bills as Percent of Total FFS (HMO and Non-HMO) Bills
Total	45%	46%	228,619	100%	6%	2%
Five Highest-Volume BETOS Categories						
Emergency Room Visit	22	22	46,456	20	33	15
Office Visits – Established	53	50	26,656	12	2	1
Specialist Visits – Psychiatry	91	90	19,593	9	17	6
Lab Test	52	47	12,032	5	11	2
Minor Procedures (misc.)	47	65	11,206	5	6	2
Note: BETOS is Berenson – Eggers Type of Service, Centers for Medicare & Medicaid Services.						

Four significant caveats are associated with this analysis. First, payment averages used to construct the 125 percent threshold underestimate the actual HMO plan-maximum payment rates to the degree that some participating providers bill below the allowable fee limits established by the plan. That should, in principle, result in a conservative (low) estimate of the fraction of bills that do not meet the true 125 percent threshold. Second, the three Medicare payment regions in Maryland were used as the geographic units for the analysis (the metropolitan area of Washington DC, the Baltimore metropolitan area, and the remainder of the state). Third, average payment per service to participating providers (for a given plan, region, and service) was used as the basis for calculating the estimated 125 percent threshold. Finally, unlike the remainder of this report, this analysis includes only physicians, and excludes bills from nonphysician practitioners.

³⁵ The statute does not establish how the payers must define the in-network rate.

³⁶ Maryland Health Care Commission and Health Services Cost Review Commission, *Study of Reimbursement of Health Care Providers, Required Under HB 805 (2002)*. (Baltimore, MD: MHCC and HSCRC, January 2004).

³⁷ Current Maryland law requires that HMOs pay a nonparticipating physician the greater of 100 percent of what is paid to a similar nonparticipating provider or 125 percent of the rate paid to a similar participating provider in the same geographic area. There is no requirement that the HMO use the average rate for an area.

Payments for nonphysician practitioners. A second issue before the General Assembly is whether to require insurers to pay nonphysician practitioners at the same rate as physicians. This analysis examines payments for the services produced by each type of nonphysician practitioner, comparing them to rates for identical services provided by a physician. This isolates the pure impact of price discounting for nonphysician practitioners from variations in payment that are due to the mix of services that the practitioner provides.

Most nonphysicians were paid rates that average 80 to 90 percent of the rates paid to physicians for the same services (Table 3-3). The notable exception was clinical social workers, who were paid an average of about two-thirds of the rates paid to physicians. The results shown here for 2002 are similar to the results shown in last year's Practitioner Report for individual services using 2001 data.

Table 3-3: Comparison of Per-Service Reimbursements to Physicians and Nonphysician Practitioners, Non-HMO Plans, 2002

Nonphysician Practitioner	Average Payment Rate as Percent of Physician Rate	Percent of all Professional Services Payments, 2002
Physical Therapist	85%	3.5%
Chiropractor	81	2.5
Psychologist	87	1.5
Podiatrist	91	1.3
Clinical Social Worker	66	1.1
Optometrist	88	0.4
Occupational Therapist	88	0.1
Audiologist/Speech Pathologist	86	0.1
Notes: Certified Registered Nurse Anesthetists are not included in this analysis.		

The estimates in Table 3-3 reflect the service mix of each individual nonphysician practitioner specialty. Thus, the numbers show how much less the plans paid by using nonphysician practitioners to produce that set of services than they would have paid if they had used physicians to produce the identical set of services.

These objective data on the rates actually paid cannot address the issue of the reasonableness or fairness of the rates. In particular, very limited data suggests that nonphysician practitioners may have lower costs than physicians providing the same services, particularly malpractice insurance costs.³⁸

³⁸ MHCC and HSCRC, *ibid*.

In addition, insurers do not pay the same rates to all physician specialties, at least when compared to the Medicare RVUs. Table 3-4 shows payment per RVU, by specialty, for non-HMO plans, for specialties accounting for at least 1 percent of spending, excluding independent laboratories. In general, the level of private payment (using Medicare RVUs as the basis of comparison) is somewhat related to the proportion of practice that is devoted to procedures rather than to office visits, with procedure-intensive specialties being paid more per RVU, on average.

Table 3-4: Payment per Relative Value Unit (RVU), by Specialty, Non-HMO Plans, 2002

Classification	Payments (\$millions)	Payment Per RVU, 2002
Nonphysician Practitioners	\$200	\$35.66
Chiropractor	33	32.60
Physical Therapist	32	41.53
Psychologist	14	31.80
Podiatrist	12	33.25
Physicians, Total	\$783	\$38.27
Physicians, Medical Specialties	433	37.89
Internal Medicine	91	35.83
Pediatrics	64	34.28
Family and General Practice	60	37.41
Cardiology	43	42.66
Emergency Medicine	27	51.60
Oncology	24	33.54
Gastroenterology	24	44.95
Dermatology	23	32.35
Neurology	18	43.74
Psychiatry	14	38.65
Physicians, Other Specialties	219	39.21
Radiology	114	38.97
Obstetrics/Gynecology	83	37.40
Pathology	21	49.56
Physicians, Surgical	130	38.00
Orthopedic Surgery	40	39.17
General Surgery	24	40.78
Ophthalmology	20	31.12
Otology/Laryngo/Rhino/Otolaryngology	16	38.18
Urology	15	39.30
Notes: Practitioners whose specialty could not be uniquely determined accounted for 14 percent of spending and are omitted from this table. Specialties accounting for less than 1 percent of spending are not shown. Detail may not add to totals due to rounding.		

The Comprehensive Standard Health Benefit Plan. A final issue relevant to Maryland policymakers is cost growth in the Maryland CSHBP. The Maryland legislature created the CSHBP as a standard, regulated insurance product to be offered to small businesses in Maryland, and limited the average premium to 12 percent of the average Maryland wage in 2002.³⁹ The structure of the benefit must be revised if the premium exceeds that level, and in 2002 the average CSHBP premium was near the affordability cap.⁴⁰

³⁹ Senate Bill 477 passed in 2003 lowered the affordability cap to 10 percent of the average Maryland wage. The changes that MHCC made as a result of the new law affect policies written after July 1, 2004.

⁴⁰ Maryland Health Care Commission, *Annual Review, Comprehensive Standard Health Benefit Plan for Year Ending December 31, 2002*, (Baltimore, MD: MHCC), October 2003.

The lack of complete enrollment data for the MCDB makes it difficult to fully compare the CSHBP to other forms of group coverage. One issue that can be examined, however, is whether the burden of patient out-of-pocket costs differs substantially between the CSHBP plans and other types of coverage in Maryland. That is, whether the structure of benefits purchased under the CSHBP is still within the mainstream of Maryland private health insurance coverage. In 2002, 20 percent of fee-for-service payments for practitioner services in CSHBP coverage were paid by the enrollee. This places the average CSHBP plan well below the out-of-pocket share for individual purchase coverage (due mainly to the typical out-of-pocket for non-HMO individual purchase coverage), but somewhat higher than the out-of-pocket share of typical employer and public employee coverages.

These results are consistent with anecdotal information from payers, employers, and insurance brokers that participate in the small group market. Deductibles and co-payments allowed in the small group are above levels typically found in the large group market. Small employers often add insurance riders that “buy-down” deductibles and co-payments so that they are more in line with benefits offered in the large group market. However, these buy-downs frequently absorb only a portion of the difference in the patient’s share of payments. Table 3-5 confirms that out-of-pocket shares in the CSHBP are higher than what is typically seen in the large group market, but considerably lower than cost-sharing in the individual market.

Table 3-5: Patient Out-of-Pocket Share of Fee-For-Service Practitioner Payments, by Plan Type, 2002

Coverage Type	Out-of-Pocket share of total Payments, All Fee-for-Service	Out-of-Pocket share of total Payments, HMO Fee-for-Service	Out-of-Pocket share of total Payments, Non-HMO Fee-for-Service
Individual Plan	39%	13%	43%
Employer–Self-funded	14	10	16
Employer–Insured	13	12	15
Public Employee	13	10	14
CSHBP	20	14	23
Taft-Hartley Trust	6	--	6
Note: There was no HMO FFS spending for Taft-Hartley Trust plan coverage reported in the MCDB in 2002.			

4. Summary and Conclusions

This section of the report briefly lists the main findings of the analysis of the 1999 through 2002 MCDB data.

- Average practitioner fees by private payers in Maryland were more or less unchanged from 1999 to 2001. Since that time, they have begun to rise, and as of April 2003, average fees were 3 percent higher than they were in 1999.
- Private fees in Maryland tend to average near Medicare's rates, but this varies by year and by type of service. Medicare pays higher rates for office visits than Maryland private payers do, but Medicare pays less for most procedures and tests.
- The only category of services that grew slowly in 2002 was major surgical procedures. Consistent with this, spending growth for surgeons was much lower than for other practitioners.
- The majority of HMO payments to nonparticipating physicians did not exceed the statutory threshold of 125 percent of payment to participating physicians. The fraction of bills meeting that threshold did not significantly change between 2000 and 2002. A substantial fraction of bills still do not appear to meet that threshold, but the total dollars involved in raising rates to meet the threshold is not large.
- In some instances, Maryland insurers pay less to nonphysician practitioners than to physicians for the same services. On average, payment rates per RVU for nonphysician practitioners are about 10 percent lower than rates paid to physicians, although some nonphysician groups have rates nearly comparable to the rates paid to physicians.
- Factors other than providers' costs, or a desire for uniform payment rate for a service, may play a role in determining payment levels. Payers may reimburse physicians at different rates depending on physician supply and adequacy of participation in the network, or on less easily quantified factors such as a provider's quality reputation or preeminence in their field.

Appendix A

Payers Contributing Data to This Report

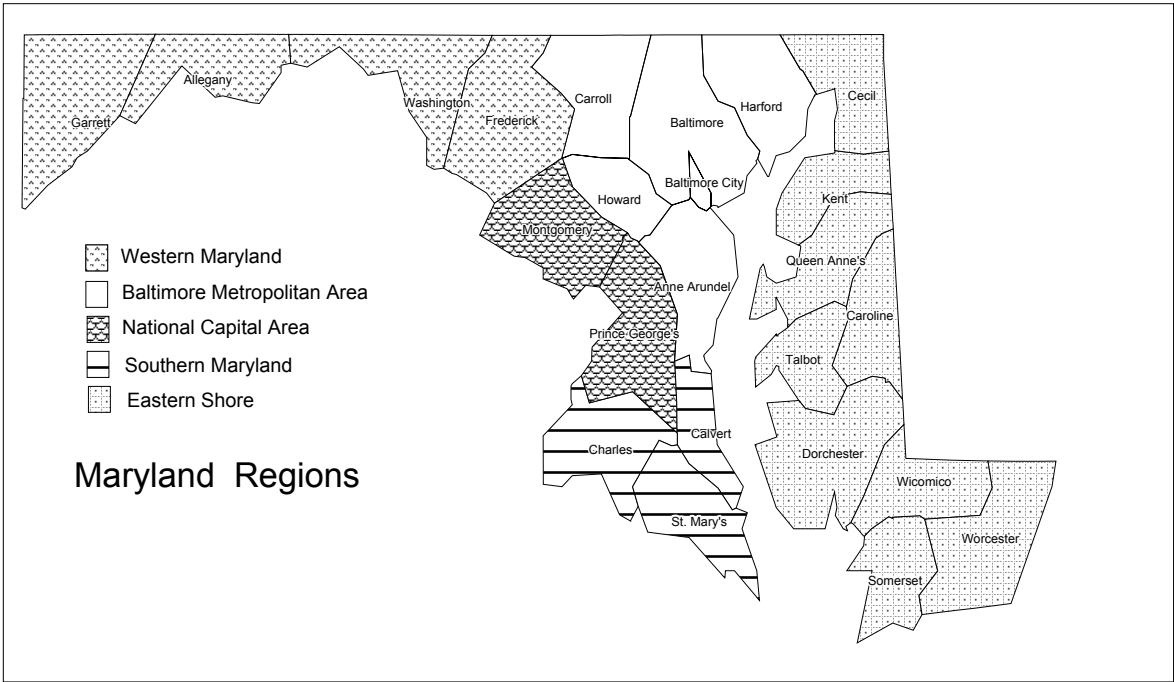
TABLE A-1: PAYERS CONTRIBUTING DATA TO THIS REPORT

Payer Name
Aetna Life and Health Insurance Co.
Aetna U.S. Healthcare, Inc.
Allianz Life Insurance Co. of North America
American Republic Insurance Co.
Carefirst – BCBS of DC, Inc.
Carefirst – BCBS of MD, Inc.
CIGNA Healthcare Mid-Atlantic, Inc.
Educators Mutual Life Insurance Co.
Fortis Insurance Co.
Golden Rule Insurance Co.
Graphic Arts Benefit Corporation
Great-West Life and Annuity Insurance Co.
Guardian Life Insurance Co. of America
Unicare Life and Health Insurance Co.
Kaiser Foundation Health Plan of Mid Atlantic
MAMSI Life and Health Insurance Co.
Maryland Fidelity Insurance Co.
MD-Individual Practice Association, Inc.
Optimum Choice Inc.
PHN-HMO, Inc.
Coventry Healthcare of Delaware, Inc.
State Farm Mutual Automobile Insurance Co.
United Healthcare Corporation
Trustmark Insurance Co.
Union Labor Life Insurance Co.
United Healthcare of the Mid-Atlantic, Inc.

Appendix B

Map of Maryland Regions

FIGURE B-1:
MAP OF MARYLAND REGIONS





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